DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45 d 8/24/13

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445458	A. BUILDING _____ B. WING _____	07/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS HEALTH CARE CENTER	1101 PERSIMMON RIDGE RD JONESBOROUGH, TN 37659

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #31632, were completed on July 8 - 10, 2013. Deficiencies were cited related to complaint investigation #31632 under 42 CFR Part 482.13, Requirements for Long Term Care Facilities.	F 000	This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow physician's orders for one resident (#111) of thirty-two residents reviewed. The findings included: Resident #111 was admitted to the facility on January 23, 2012, with diagnoses including Presenile Dementia, Chronic Ischemic Heart Disease, Hypertension, Chronic Kidney Disease, Congestive Heart Failure, Osteoarthrosis, History of TIA/Stroke without residual, and Anemia. Medical record review of the Nursing Notes revealed the resident expired on April 13, 2013. Medical record review of a Physician's Order	F 309	F 309 1. Resident # 111 is no longer a resident at the facility. 2. The Director of Nursing, the Assistant Director of Nursing, and the Regional Director of Clinical Services reviewed all medication orders for accuracy on 7/9/13. No other residents were identified as being affected. 3. Licensed nurses were in-serviced on ensuring all medication orders are accurately followed from 7/9/13 – 7/12/13 by the Staff Development Coordinator, the Assistant Director of Nursing, and the Director of Nursing.	8/1/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Doris J. Coodman | TITLE: Administrator | (X6) DATE: 7/22/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445458	A. BUILDING _____ B. WING _____	07/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS HEALTH CARE CENTER	1101 PERSIMMON RIDGE RD JONESBOROUGH, TN 37659

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 1 dated March 21, 2013, revealed the resident began receiving hospice services. Medical record review of a Physician's Order dated April 11, 2013, at 8:20 p.m, revealed the resident was to receive Roxanol (pain medication) 20 mg/ml (milligrams per milliliter), 1 ml sublingual (under the tongue) every two hours, and Roxanol 20 mg/ml, 0.5 ml every four hours was to be discontinued. Medical record review of the April 2013 Medication Administration Record (MAR) revealed the Roxanol 0.5 ml every four hours was discontinued on April 11, 2013. Continued review of the April 2013, MAR revealed the Roxanol 0.5 ml was restarted on April 12, 2013, at 4:00 p.m., and administered by Licensed Practical Nurse (LPN) #1. Medical record review revealed no Physician's Order to restart the Roxanol 0.5 ml on April 12, 2013. Interview on July 9, 2013, at 4:45 p.m., with LPN #1, in the Director of Nursing's office, revealed on April 12, 2013, the resident's family was at the bedside and wanted pain medication administered to the resident. Continued interview revealed another Nurse had told LPN #1 the Roxanol 0.5 ml was to be administered to the resident every four hours in addition to the Roxanol 1 ml every two hours. Continued interview confirmed LPN #1 had transcribed the Roxanol 0.5 ml every four hours onto the MAR, incorrectly on April 12, 2013, after looking at the order to discontinue the Roxanol 0.5 ml every four hours written on April 11, 2013. Continued	F 309	4. An audit of 10 Medication orders will be completed daily for 1 week, weekly for 3 weeks, and monthly for 2 months and/or 100% compliance by the Director of Nursing, the Assistant Director of Nursing, the Staff Development Coordinator, and the Charge Nurses. The results of the audits will be presented by the Director of Nursing to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Assistant Director of Nursing, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445458	A. BUILDING _____ B. WING _____	07/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS HEALTH CARE CENTER	1101 PERSIMMON RIDGE RD JONESBOROUGH, TN 37659

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 2 interview and review of the April 2013 MAR confirmed the Physician's Orders were not followed and the resident received, in error, four doses of the Roxanol 0.5 ml on April 12, 2013, at 4:00 p.m. and 8:00 p.m., and on April 13, 2013, at 12:00 a.m. and 4:00 a.m. Telephone interview on July 9, 2013, at 5:00 p.m., with the Physician, revealed the resident was near death, experiencing pain, needed pain control, was receiving hospice services, and the administration of the additional Roxanol caused no ill effects to the resident.	F 309		
F 323 SS=D	C/O #31632 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was in place for one resident (#32) of thirty-two residents reviewed. The findings included: Resident #32 was readmitted to the facility on March 4, 2011, with diagnoses including Cervical	F 323	F 323 1. Resident #32 was immediately placed in the correct wheelchair with the safety device in place by the Assistant Director of Nursing on 7/9/13. Resident #32 was assessed by nurse on 7/9/2013 and no adverse outcomes noted. 2. The Director of Nursing and the Assistant Director of Nursing reviewed all safety devices in the facility on 7/9/13. No other residents were identified as being affected. 3. Licensed nurses and the Certified Nursing Assistants were in-serviced on ensuring safety devices are in place when ordered by the physician and/or on the Plan of Care from 7/9/13 – 7/12/13 by the Staff Development Coordinator, the Assistant Director of Nursing and the Director of Nursing.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445458	A. BUILDING _____ B. WING _____	07/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS HEALTH CARE CENTER	1101 PERSIMMON RIDGE RD JONESBOROUGH, TN 37659

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3 Spinal Stenosis, Vascular Dementia with Depression, Atrial Fibrillation, and Congestive Heart Failure. Medical record review of the fall risk assessment dated July 5, 2013, revealed the resident was at high risk for falls. Medical record review of the Physician's Recapitulation Orders dated July 1, 2013 through July 31, 2013, revealed "...Anti Roll Backs to W/C (wheelchair)..." Medical record review of the Care Plan dated June 2, 2013, revealed "...Potential for falls...anti-roll backs in w/c..." Observation on July 9, 2013, at 1:30 p.m., with Licensed Practical Nurse #3, revealed the resident seated in a w/c, in the hall, without the anti-roll backs to the w/c. Interview on July 9, 2013, at 3:35 p.m., in the conference room, with the Director of Nursing confirmed the resident was to have the anti-roll backs on the w/c.	F 323	4. An audit of all safety devices will be completed daily for 1 week, weekly for 3 weeks, and monthly for 2 months and/or 100% compliance to ensure safety devices are in place according to physician order and/or Plan of Care by the Director of Nursing, the Assistant Director of Nursing, the Staff Development Coordinator, and the Charge Nurses. The results of the audits will be presented by the Director of Nursing to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Assistant Director of Nursing, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514	F514 1. Resident #111 is no longer a resident at the facility. 2. Medication Administration records were audited for correct documentation on 7/9/13 by the Director of Nursing, and the Regional Director of Clinical Services. Issues identified were addressed immediately.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445458	A. BUILDING _____ B. WING _____	07/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS HEALTH CARE CENTER	1101 PERSIMMON RIDGE RD JONESBOROUGH, TN 37659

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 4 resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a complete medical record for one resident (#111) of thirty-two residents reviewed. The findings included: Resident #111 was admitted to the facility on January 23, 2012, with diagnoses including Presenile Dementia, Chronic Ischemic Heart Disease, Hypertension, Chronic Kidney Disease, Congestive Heart Failure, Osteoarthrosis, History of TIA/Stroke without residual, and Anemia. Medical record review of a Physician's Orders dated April 11, 2013, at 8:20 p.m, revealed the resident was to receive Roxanol (pain medication) 20 mg/ml (milligrams per milliter), 1 ml sublingual (under the tongue) every two hours. Medical record review of the April 2013 Medication Administration Record (MAR) revealed no documentation the resident had received the Roxanol on April 12, 2013, at 12:00 p.m., and 2:00 p.m. Interview on July 9, 2013, at 1:00 p.m., with Licensed Practical Nurse (LPN #2), in the Director of Nursing's office revealed the Roxanol was administered as ordered, however LPN #2	F 514	3. Licensed Nurses were in-serviced from 7/9/13 – 7/12/13 on correct documentation on the Medication Administration Record by the Director of Nursing, the Assistant Director of Nursing, and the Staff Development Coordinator. 4. An audit of 10 Medication orders for correct documentation will be completed daily for 1 week, weekly for 3 weeks, and monthly for 2 months and/or 100% compliance by the Director of Nursing, the Assistant Director of Nursing, the Staff Development Coordinator, and the Charge Nurses. The results of the audits will be presented by the Director of Nursing to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Assistant Director of Nursing, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445458	A. BUILDING _____ B. WING _____	07/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS HEALTH CARE CENTER	1101 PERSIMMON RIDGE RD JONESBOROUGH, TN 37659

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 5 confirmed the administration of the Roxanol was not documented on the MAR. C/O #31632	F 514		